

Frederick County Child Health Partnership Focus Group Report

Purpose of the study

During the initial Frederick County Child Health Partnership (FCCHP) retreat in May 2007, it was decided that focus groups would be held throughout a variety of communities within Frederick County to gain insight into parental perceptions of the problem of childhood obesity and community assets available to address the issue. The FCCHP partners agreed to recruit community members and key stakeholders for participation in focus groups. Core Health was retained to facilitate four focus groups. Initial attempts were made to recruit participants in the following groups: (associated names are the FCCHP members who agreed to recruit members):

- 1. Upper/Middle Income Martha Herman and Daria Putnam-Steinhardt
- 2. Lower Income Rebecca Comstock and Susan Lindstrom
- 3. Families who have children already in programs Dr. Lee/Frederick County Health Department (FCHD)
- 4. A Smorgasbord (an assortment of Frederick County residents) Deborah Rhodes

This initial focus group participation plan was modified when difficulty in scheduling and recruitment occurred. The new groups identified were:

- 1. Even Start Program members-Recruited by Elizabeth Chang, YMCA
- 2. A smorgasbord group-Recruited by Dr. Jacqueline Dougé, FCHD and varied FCCHP partners.
- 3. Nursing personnel from Fredrick Memorial Hospital and FCHD, local business owners, and varied community residents-recruited by Dr. Jacqueline Dougé.
- 4. Ft. Detrick Army Base: Boy & Girls Club parents, military personnel and civilian personnel. Recruited by Boys & Girls, Charmayne McClarine

The purpose of the focus groups was to learn more about the community's attitude and perceptions regarding childhood overweight and obesity while gaining insight on what community assets were currently available to assist parents or children facing this challenge. The focus group design allowed facilitators to assess participants' perceived social, cultural and economic barriers to changing unhealthy behavior patterns and explore potential approaches for overcoming those barriers.

Methodology

The focus groups were conducted by two seasoned facilitators: Gloria WilderBrathwaite, MD, MPH and Rahsaan Bernard, MBA, CPT, CSN. Participants were guided into a discussion about aspects of a "healthy life" for children and then allowed to define aspects of "unhealthy behavior" in minors.

Participants were asked to read disclosure statements (detailing procedures and expected outcomes) prior to commencing the focus groups (See Appendix A). Participants were reminded that all comments would be kept confidential. Reports and data analysis would be void of any identifying information. Participants agreed to have their responses recorded using an audio device to facilitate accurate transcription.

Focus group participants were given a written demographic sheet (consisting of 14 questions) at the beginning of the session (See Appendix B). Data collected was analyzed and used to identify participants' ages, income level, race, education level, and top concerns about children.

Using scripted questions that were populated with a heterogeneous audience (different residents of Frederick County), the facilitators obtained qualitative data that could be analyzed to uncover a range of perspectives and themes related to the issue of childhood overweight. It must be noted that the small sample sizes and non-random selection of participants for these focus groups prevent using the findings to draw cause and effect relationships or to generalize the results to the wider population from which the participants were taken. A consensus around a result, may describe "a dominant", "widely held or expressed" belief.

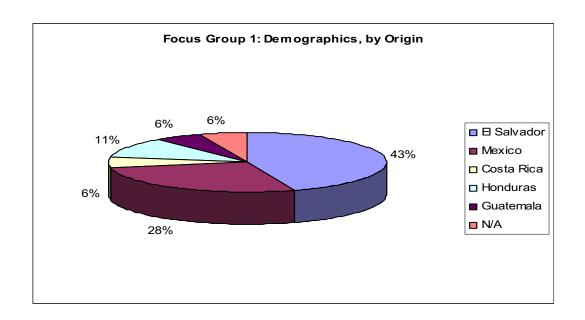
Focus group participants were guided into discussions through the use of several open-ended questions drawn from twenty-one (21) pre-scripted questions (See Appendix C). Facilitators used probes and open brainstorming techniques to control the tempo of discussions and to optimize uniform participation. The flexibility and openness of the discussions allowed the participants to feed off each other thus making the responses a richer woven tapestry of ideas.

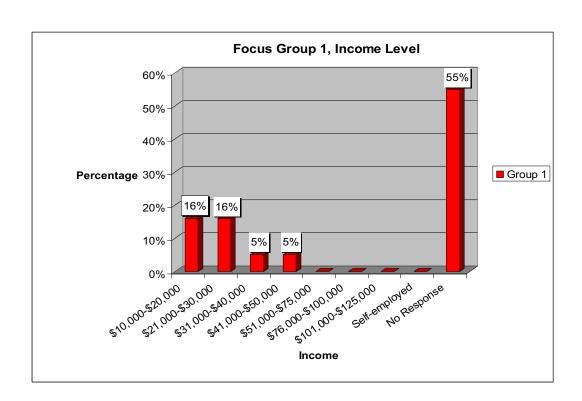
Focus Groups (general characteristics) and Design

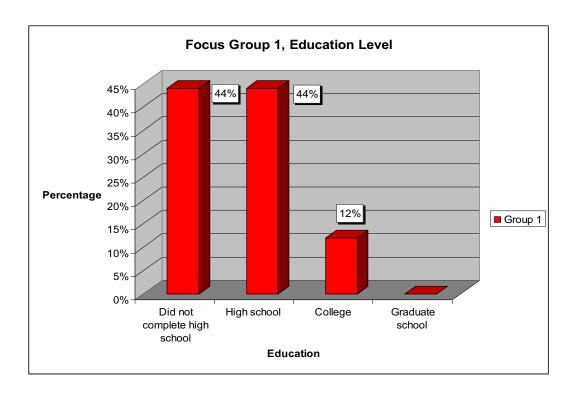
Two focus groups were conducted on September 26, 2007 and two on October 3, 2007. The groups were identified and recruited by the Frederick County Child Health Partnership. During recruiting, participants were told that focus groups were being held to discuss the issue of childhood overweight in Frederick County. Participants were informed that they would be given a \$20 grocery gift card and pedometers as an incentive for their participation. In addition, refreshments were provided to program participants at the time of the focus group. In all, fifty-four individuals participated in the study. Below are generalized characteristics of each focus group:

Focus group 1

On September 26, 2007, at 11am, the first focus group was held at the Even Start Program at Hillcrest Elementary School, a program designed to improve parental and child literacy. This group consisted of 18 Hispanic women, all migrants from other countries, with ages ranging from 19yrs to 42yrs. All were residents of Frederick County; all were parents of at least one child; only two of the eighteen participants had more than a high school education and all fell within 100% of the poverty line. It is to be noted that the Even Start Program members were all native Spanish speakers and only a few were proficient in English. This session was conducted using translation services facilitated by trained Core Health staff.

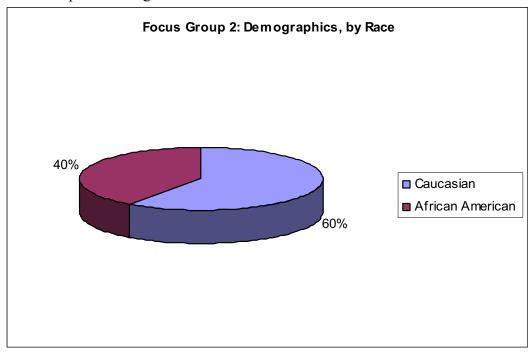


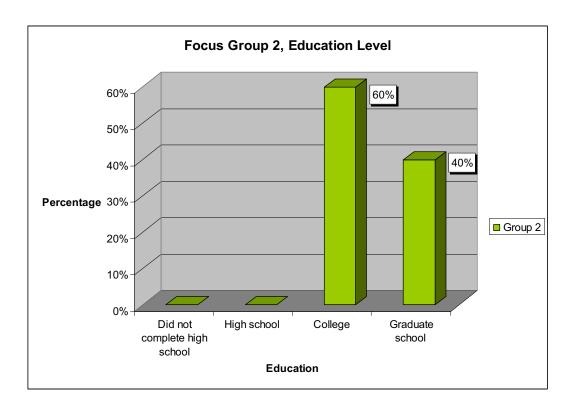




Focus group 2

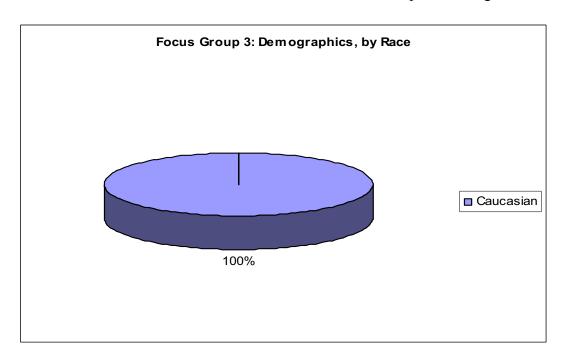
The second focus group was held on September 26, 2007 at 2:30pm at the Frederick County Health Department. The group consisted of a smorgasbord - five parents - three Caucasian (one female, two male) and two African American (one female, one male). All but one were native born Americans, with age ranging from 29yrs to 48yrs, all were residents of Frederick County and were parents of at least one child, and all had completed college.

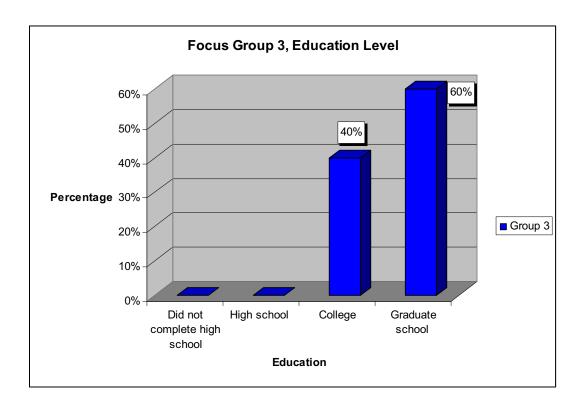




Focus group 3

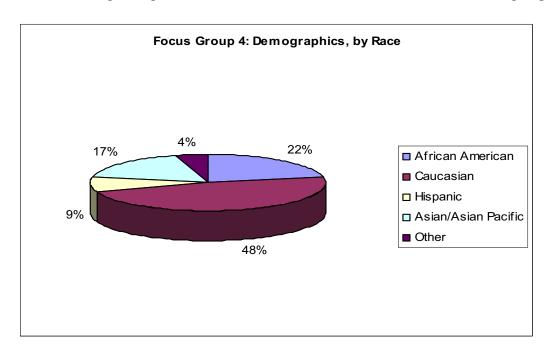
On October 3, 2007 at noon, the third focus group was conducted at the Frederick County Health Department. This group consisted of five members: healthcare professionals (nurses), local business owners and community residents with age ranging from 35yrs to 44yrs. All were born in the United States, all were Caucasian females, all had at least one child, and all completed college.

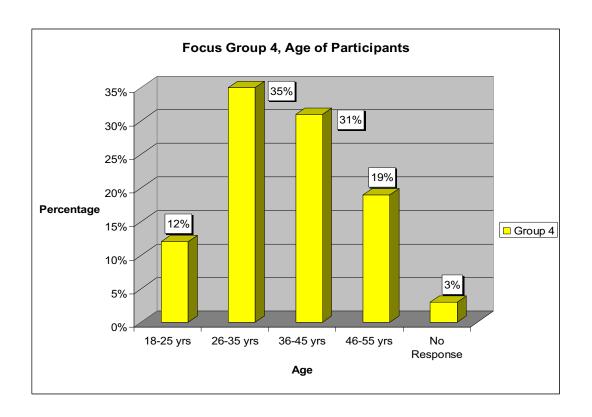


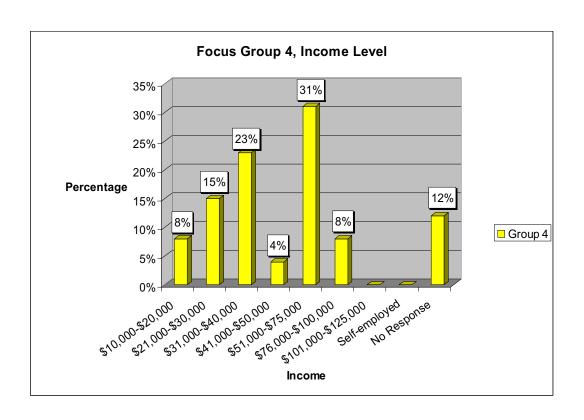


Focus group 4

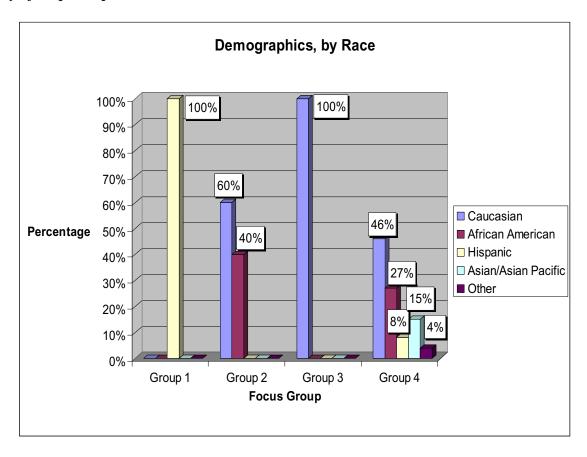
The fourth group on October 3, 2007, held on the Fort Detrick Army base was so well attended (26 participants) that the facilitators shifted into a community dialogue (town hall format). This group consisted of enlisted (some spouses) and civilian workers. Participants with varying nationalities, ages ranging from 19yrs to 53yrs, all but two of the twenty-six had at least one child, varying income levels up to \$100,000 and most being college educated. Gender breakdown is not available for this group.

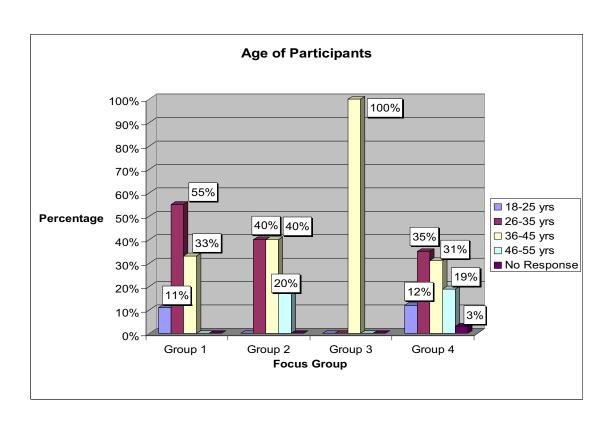


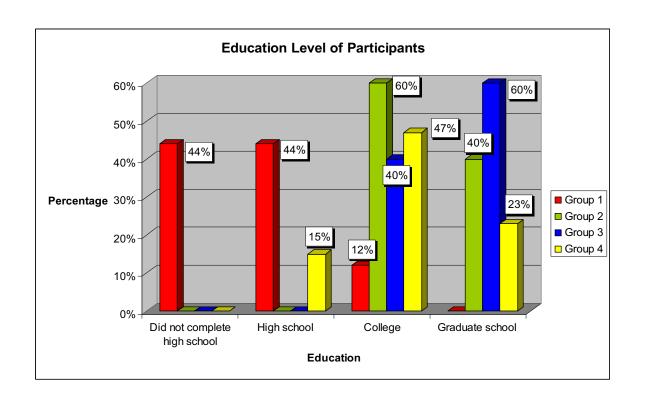


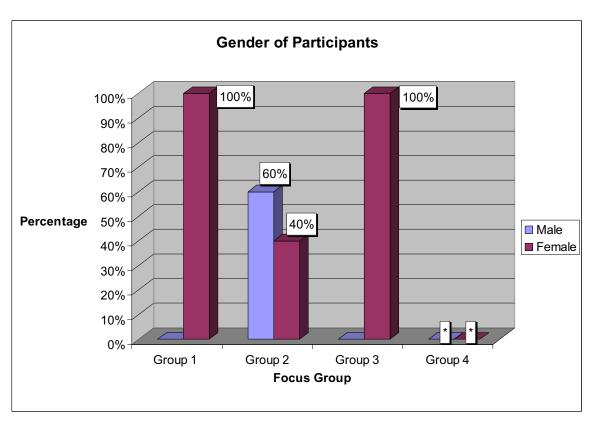


Summary of all participants:









^{*} Gender data for focus group 4 was unavailable at the time of analysis.

Results

Defining a healthy child

All focus group conversation was initiated with - "How would you define "healthy" for a child?" Respondents had different definitions of what it means to be healthy. For example, Focus Group 1: the women of Latin descent defined a healthy child as one who is:

"Skinny"...... "In our society today, everyone wants to be skinny"

This definition differed from Focus Group2 members who identified that a child is healthy when they are: "Clean, have energy, good teeth versus being lethargic."

Focus Group 4 defined healthy as...

"Playing, age appropriately"

With parents of military children defining healthy as

"Physical mobility and cognitive ability"

The words "happy" "active" and "energy" were pervasive in the feedback received from all the focus groups. None of the groups expressed a child who is overweight, chubby or inactive as healthy.

It is apparent from the responses received from this question that the denotation of the word "healthy," embodies different meaning for different groups. It is to be noted that in order for parents to begin assessing if their child is healthy or not, a consistent definition of "healthy" which encapsulates all factors of health (mental, emotional, physical, spiritual etc.) must be promoted throughout the community. This is necessary both to establish a clearer and more accurate understanding of what "healthy" means, but also to minimize the negative stereotype, (e.g., "skinny = healthy") that go along with the pop culture.

Overweight vs. Obese

Understanding how the participants perceived the terms "overweight" and "obesity" can greatly impact how information about the associated health risks is communicated to their families. As part of the focus group questioning process, participants were asked to comment on the difference between overweight and obesity. Several themes emerged from the discussion groups.

The majority of Focus Group 1: members (women of Latin descent) defined obese as:

"More than overweight,"

Members of this group also stated that chubby babies less than one year of age were not seen by them as overweight or obese. After one year of age is when they made the association between weight and health status.

When asked to differentiate between overweight and obese in a child, Focus Group 2 had definitions that included:

"If their midsection is bigger"

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"Huffing and puffing during exercise"
"There is no difference; it's about symmetry."
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The third focus group (Caucasian women) had more dire definitions when discussing obesity vs. overweight:

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"Irreversibility"
"Mobility impairment"
"Negligence"
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Focus group 4 (Fort Detrick participants) displayed a number of areas of disagreement linked to the status of the respondent. Active duty and enlisted participants repeatedly relayed their confidence that their children were more fit than regular children in Frederick County because of their "culture of fitness and nutrition" that is inherent in military life. However, when the discussion of healthy food choices arose, spouses of military members (stay at home mom and dads) agreed they did not know what healthy foods to feed their child and further introspection revealed they were feeding their child the same unhealthy snacks that parents off the base were. Military spouses also shared a number of similarities with civilian employees in feeling isolated on base. There was a stark difference here with both male and female enlisted/military members who expressed confidence in their ability to teach their children a healthy lifestyle and proud of the many facilities available on base to promote fitness (indoor and outdoor pools, running tracks, gyms, playgrounds, etc.). Civilian employees expressed frustration at the difference in availability of health promoting facilities on and off the base. One woman expressed how on base the enlisted had access to two pools, gyms, running and bike trails. The woman lives only a few miles off base and she relayed that she must drive a far distance to get her children to a decent county facility. She also expressed that playgrounds close to her house were in disrepair.

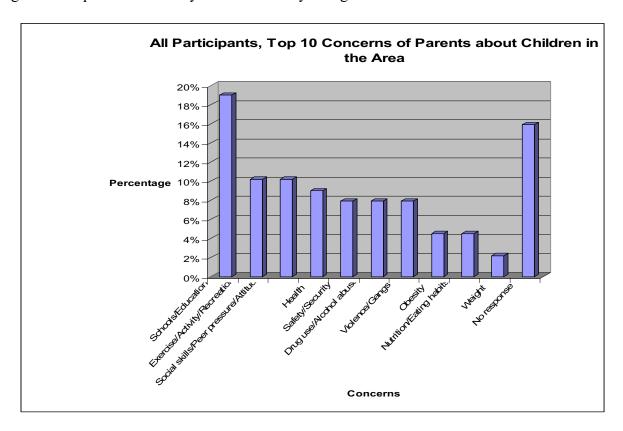
Participants in all the focus groups had various definitions for overweight and obesity. A few of the definitions reflected a basic clinical understanding of childhood overweight. None mentioned the Body Mass Index definition for obesity. There was agreement that childhood overweight is a problem in their community that must be addressed. Most respondents commonly defined overweight and obesity on a case-by-case basis—dependent mostly on individual appearance rather than scientifically accepted weight categories. This may indicate an inability to accurately identify personal weight status or the weight status of their children, and should be considered when developing messages and resources for this community.

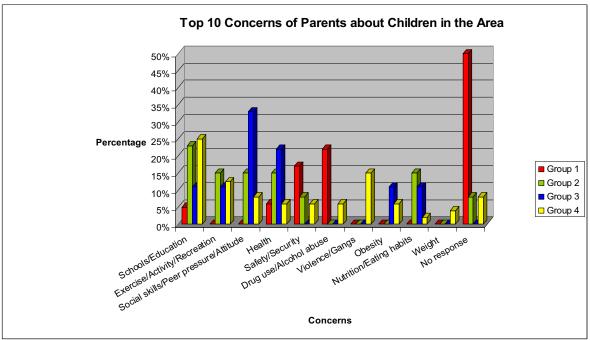
Childhood nutrition and fitness education availability

Fitness and nutrition was in the top ten of concerns for participants in our focus groups: schools and social skills ranked first and second respectively. When the discussion about food and nutrition availability surfaced, there was consensus that unhealthy vending machine snacks and poor school lunch choices are a problem in Fredrick County schools. Participants recommended better coordination between the Department of Health, Parent Teacher Association (PTA) and the Frederick County School system to work collaboratively to address this issue. They also suggested that children should be educated in reading nutrition labels and given overall nutrition education to assist them in making healthier choices. Moreover, since most of the decisions on food consumption for children are made by parents in the home, the participants agreed that parents should be educated on healthy eating habits and how to read nutrition labels.

The dichotomy between a perception of health and what really happens in the home begs the question — How are parents educated in the community about healthy eating and proper nutrition? It must be noted that regardless the perception of healthy living, parents must be educated on what it means to prepare

healthy nutritious meals for their children. Perception, image and zeal are not enough, education and messages that inspire are necessary tools for healthy living.





Parents can have a profound influence on their children by serving as a role model and promoting healthy eating and an active lifestyle but this must be accomplished through proper knowledge of what it means to eat healthy. Consistent nutrition messages must be created that are culturally sensitive reflect a range of literacy levels and contain appealing, non-judgmental themes.

Environmental Health

The link between environmental influences and childhood obesity cannot be overstated. When asked to reflect on how their environment impacts their child's weight, eating habits, exercise habits and overall well being, parents gave a number of important comments:

At Fort Detrick (Focus Group 4), parents expressed a disconnect between living on a military base vs. living off of the military base. They felt:

"Military parents and children are healthier because of the [military] base."

In fact, at the beginning of the focus group many group members stated proudly that their child was active and healthy because of the environment of the base. One parent stated

"This is just how it is here"

commenting on the fact that endemic to base life is an attitude of fitness and health. They concluded that resources were available to them such as safe and secure outdoor activities, healthy school lunches, walking and running trails, and youth service centers including the Boys & Girls Club, YMCA, and an open gym for children. Parents stated that many of these benefits were not accessible just a few miles off of the base resulting in poorer eating habits and less physical activity. The group purported that the perception of "safety" "discipline" and "structure" of the army base has direct correlation of how much physical activity a military child receives. In fact, one parent mentioned that as a military parent she believed so strongly in exercise for her child that even she incorporates physical activity as a tool for correction. She mentioned:

"I even have my son do push ups for his punishment"

The overarching idea was that parents who reside on the military base feel safe with allowing their child to go outside and play. A reality that one parent of the group stated she does not enjoy because she lives off the base and feared that her child would be harmed if left outside to play in her neighborhood.

Another factor for some focus group participants was the absence of sidewalks in their communities. Participants from both focus groups 2 and 3 stated that their children were not able to walk or ride their bikes near their houses because of a lack of sidewalks. Participants from focus group 1 (women of Latin descent) stated:

"There not a lot of safe places to walk and there are no sidewalks in our communities."

"It is hard pushing baby strollers without sidewalks."

Participants also discussed the unavailability of facilities for them to utilize for activity. A participant from focus group 1 stated:

"Parks are not in our area."

Transportation and finance barriers

Participants also emphasized transportation as a barrier to receiving quality health care and professional advice. They described areas of the county which have a lack of public transportation, or inaccessible

hours of transportation (buses only running on the hour, no service in the evening or weekend), and the inconvenience of relying on public transportation for visiting a health care provider. They stated that buses do not operate frequently and using taxi services is too costly. Respondents from focus group 1 (women of Latin descent) who were all low income stated:

"You have to take two or three buses to get to one location. This is very hard when you have more than one child."

The impact of income on the issue of overweight and obesity in children was evident from a respondent from focus group 2, who stated:

"As a single mother you have to make a choice [about fresh foods vs. canned foods]. I have a strict budget."

A parent from focus group 4 (military personnel) stated:

It is evident that for many parents the reality they face is one of long work hours, little time to prepare meals and limited budgets for food or recreation. The easy accessibility and low cost of fast food only exacerbates the issue of childhood obesity.

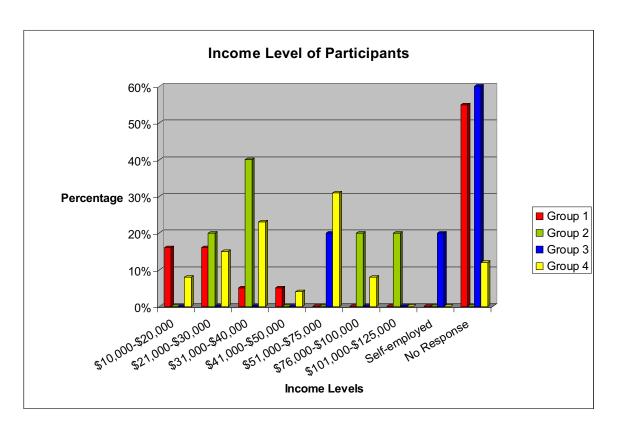
One parent commented:

"I can get fast food anywhere and it's cheap" "If it is a decision between something fast and cheap and cooking a meal getting food from the grocery store, it's something fast."

On the hand, participants of a higher income level in focus group 2 had a strong perception about their ability to control what their children ate. One woman stated that her two teenage daughters had never tried fast food or soda drinks. She knew that as they got older, they had the freedom of trying these foods but hoped that her positive reinforcement throughout their childhood would steer their desire away from consuming unhealthy food choices available in the community.

[&]quot;It is cheaper to buy a whopper than to buy a salad"

[&]quot;It is cheaper to buy a kids meal."



Low to moderate income and inadequate public transportation have put some residents at a distinct disadvantage in receiving quality care and proper access to community resources that foster a healthy lifestyle. Respondents from the Even Start program (Focus Group 1-women of Latin descent) mentioned the difficulties of using public transportation and a lack of access to parks and trails. A participant from a higher socio-economic status stated that in order for her children to use a park, they had to drive to access it. That participant understood that if she did not have the means to drive to parks, her children would not have a place for recreation and exercise.

Language, Cultural and Citizenship Barrier

An interesting dichotomy arose between the Even Start program members (Focus Group 1-women of Latin descent) and all the other groups interviewed. When the group identified where they would go to receive services for a child who is obese, the Even Start program members, consisting of all low income women, named the emergency room as a potential resource to obtain help for their children. This was the only group that named this resource and it was evident that their economic condition relegated them to this option- a location where many uninsured seek primary care. In addition, language barriers were identified as most of these mothers sought practitioners and health care professionals that not only knew their language but understood their culture.

Facilitators carefully considered the feedback and inferences of the Even Start program members in order to address the critical issues they face in the area of childhood overweight and obesity. One such inference is the issue of where the Even Start program members went for help. At first glance it appears mothers were seeking physicians who spoke their language. At second glance, it is also clear from the questionnaire given to the women that the issue of undocumented vs. documented status may play a role when it comes to choice of primary care. The Even Start members coalesced around a particular physician or group of physicians who were sensitive to their status and would render services regardless of their citizenship. The name of just a few physicians arose during the discussion, evidence that the group may not be aware of similar services in their community or may feel uncomfortable seeking care

outside of a tight network. This differed from the other groups that predominantly identified the two major medical practices in Frederick County– Frederick Pediatric Associates and Pediatric Center- as the locations for receiving primary care.

A community with a growing immigrant population must consider what perceived barriers or fears exist for families who are undocumented. Providing access to services must be married with a process that is not overly intrusive and the perception that one's family will be safe from arrest and deportation. Failure to address these issues could create a chasm that will divide the emerging immigrant community in Frederick from other residents. This could result in a population of community children who are unable to access services to prevent or treat childhood obesity and overweight.

Community Assets and Implications

A goal of the focus groups was to identify the existing assets in the Frederick County community. When facilitators asked the question "If I was moving to Frederick County tomorrow where would I go to seek help for my overweight child?" the groups listed the following assets:

Nutritionist on base at Fort Detrick
Gyms in the area open to kids
Youth services
YMCA
Parks and Recreation
Baughman's lane – farmer's market
Self Help And Resource Exchange (SHARE) program
Pediatric Center
Pediatric Associates
The WIC program at the Department of Health
Linganore Counseling and Wellness Center
Frederick Memorial Hospital Emergency Room
Frederick Memorial Hospital Wellness Center (FMH)

Some of the assets identified during the focus group overlapped the assets identified during the retreat of the Frederick County Partnership. Assets such as the Frederick Memorial Hospital Wellness Center, the YMCA, the WIC program at the Department of Health and the local Parks and Recreation were repeated.

Figure 2.1: Asset Map with newly identified assets shaded in green

Asset Mapping Categorization Chart With New Assets Added By Focus Groups In Green

	ASSET CAT	CATEGORIES				
	Clinical	Social	Fitness	Education	Counseling	Nutrition
	Frederick Memorial Diabetes Center	L & B Chamber Profit & Non- Profit	Frederick County Sports Leagues.	PE Classes Existing partners & collaboration	Maryland Co- op Ext.	Common Market
ASSETS	DOH	MD Corp. Extension	YMCA	LMB & Chamber Counsel of Non- Profit	FMH	Baughman's Lane - Farmers Market

Clinical	Social	Fitness	Education	Counseling	Nutritio
Frederick Pediatrician (Dr. Lee)	Frederick Wellness Center	DOH	YMCA	FCPS	WIC
Frederick Wellness Center	FCS facilities	Frederick County Parks and Recreation	United Way	CASS	MOM (market)
Mission of Mercy	School Health council	FMH	MCExt.	GO Program (guys only & girls only)/	DOH
Pediatric Center	FCPS	FCPS – after school programs FCPS – athletic programs	FMH Health Classes	DOH	Head St Progran
Frederick Pediatric Associates	FMH	Private clubs – for profit	FCPS – special programs FCPS – teachers	Frederick Wellness Center	Frederic County Diabete Center
	EIL	Frederick Wellness Center	Frederick Wellness Center	Linganore Counseling and Wellness Center	MD Cor Extension Service
	House of Rep. – Roscoe Bartlet Support to the collaborations				4-H Pro
	Central Hispano (referral service)				Wellnes Center s nutrition program
	Local delegate – Sue Hecht				Self He and Res Exchang Program (SHARI
	United Way				Frederic Wellnes Center
	YMCA				Nutrition Fort Det Base

A close look at the asset mapping categorization chart reveals that among the new assets identified, two assets emerge as highly influential (due the frequency with which they were referred to by participants) – Frederick Pediatric Associates and Pediatric Center. The majority of the respondents received some type of medical services for their children from these two practices. It will be important to include these two pediatric practices in follow-up discussions of messages, marketing and programs directed to impact childhood obesity and overweight in Frederick County.

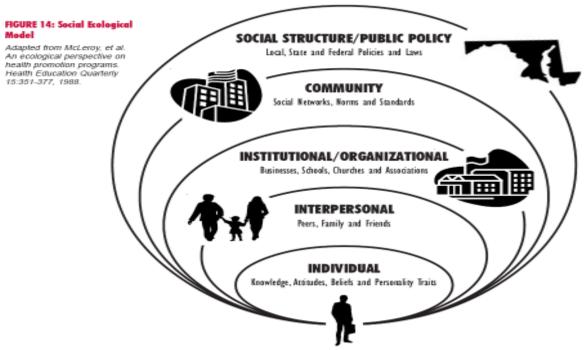
Conclusion

Overweight and obesity among youth has become a national health challenge. Obesity currently affects an estimated 1 in 6 US children. Excess body fat can become a catalyst for complex chronic conditions such as heart disease, the leading cause of death for Frederick County residents. Being overweight or obese can disable and discourage a child from participating in social activities, affecting their self-esteem and psychosocial well-being. The impact of this disease is generational and community wide.

The focus groups study findings demonstrate a clear need for a comprehensive approach to address childhood obesity among families in Frederick County. For many of these families, issues relating to daily survival such as employment, safety, limited finances, and education take priority over the issues of overweight and obesity. The general perception gathered from the focus groups is obesity poses a major risk to the lives of children. Participants felt parents are both responsible for the health and well being of their child and can have the most impact on their child's health. While respondents generally acknowledged the importance of the parent's role to provide good nutrition and ensure their children get regular physical activity, they expressed frustration and concern over time constraints, the lack of resources and community support to sustain healthy behaviors. Many participants expressed the belief that the local and federal government can do more to create policies and legislation that will aid in the fight of childhood overweight and obesity. Respondents were clear in their belief that politicians have power over issues such as creating safe places for children to play, having more sidewalks, more trails, and more low-cost programs that promote exercise. Education is tantamount to action in the Frederick Community and messages created about preventing childhood obesity must not only be culturally sensitive but inspiring and motivational. Messages must be created and distributed sagaciously in order to compete with opposing messages found in the mainstream media.

By exploring these perceptions and listening to community recommendations the Frederick County Child Health Partnership will gain valuable insight to create and deliver messages that will resonate with families around the issue of childhood overweight and obesity. In order to be successful, these messages must have effective communication channels in all the spheres of influence for a family. It is with this premise, that Core Health recommends using the Social Ecological Model as a guide. The Social Ecological Model acknowledges the various factors that influence an individual's ability and opportunity to change. It emphasizes that everyone lives within physical environments and social systems that influence their health. As a result, lasting changes in health behaviors require physical environments and social systems that support positive lifestyle habits. There are several adaptations of the Social Ecological Model; however, the initial and most utilized version is Urie Bronfenbrenner's (1977, 1979) Ecological Systems Theory which divides factors into four levels: macro-, exo-, meso-, and micro-, and describes influences as intercultural, community, organizational, and interpersonal or individual, Used by the Center of Disease Control (CDC) as a preventative framework for issues relating to violence, smoking and most recently obesity, the Social Ecological Model describes individual behavior affected through multiple spheres of influence—individual, interpersonal, institutional, community and social structure or policy. Successful behavior change is difficult to achieve and sustain without changes in the surrounding organizational, community, social and physical environments.

Figure 3.1 – Graphical Representation of the Social Ecological Model



^{*}Picture taken from NPA plan

Limitations to the Findings

Several challenges created limitations in data collection and analysis. The demographic sheets for focus group 1 (women of Latin descent) was read to the participants orally using translation services. The translation services allowed for a margin of error in collecting all of their information. The lack of response to questions pertaining to income levels and concerns for children on questionnaires submitted by focus group 1 are likely to be a communication error.

Some participants in focus groups 1, 2 and 4 did not respond to the question on income level. They may have felt uncomfortable answering the question and/or the question was misinterpreted. It is also unclear whether participants who responded to the income questions provided their individual annual income or their full household income.

Next Steps

Identify mechanisms to employ the Social Ecological Model through accomplishing the following objectives:

Institutional /Organizational/Community:

- ◆ Create and provide an active/healthy tool-kit or resource manual at the Department of Health to enable communities to access information and resources and promote healthy eating and physical activity
- Expand programs similar to the SHARE program and local farmers markets for increased access to affordable healthy food options in Frederick communities.
- ◆ Create and support mini-child health coalitions within each community to carryout the work of the Fredrick County Child Health Coalition.

Individual/Interpersonal

- ♦ Increase awareness and create a child friendly-healthy-happy message campaign to promote healthy eating and physical activity.
- Promote community wide supports for healthy family activities including recognizing single parent families and low income families who integrate healthy lifestyle choices and activities.
- Create opportunities for youth achievement in fitness, nutrition and wellness outside of traditional sporting competitions, through the arts (dance, step, cheerleading, community theatre, written word and poetry focused on wellness themes, etc).

Institutional/Organizational

- ♦ Increase the number of healthcare professionals such as Frederick Pediatrics and Pediatric Center physicians who communicate overweight and obesity prevention messages, including healthy eating, increased physical activity and decreased sedentary activity in healthcare practices on a regular basis.
- ♦ Work with healthcare finance organizations to reward pediatric and family practices that actively promote health and wellness activities for their pediatric population. Ex. funding a nutritionist or fitness trainer to rotate between pediatric practices engaging families with overweight children.

Social Structure/Public Policy

- ♦ Advocate for the expansion of sidewalks to accommodate walkers, riders, and strollers.
- ♦ Advocate for the rehabilitation of local playgrounds to ensure they accommodate a variety of pediatric age groups and levels of ability.
- ♦ Advocate for extended hours weekend and evening of county fitness facilities and public pools.
- ♦ Advocate for expansion of county sponsored little leagues, child friendly sporting events and recreation nights.
- Work with legislative leaders to address the issue of transportation barriers (bus accessibility), language access and ensuring every child has access to county sponsored health promoting activities.